WEST VIRGINIA Department of Health & Human Resources

Bureau for Behavioral Health and Health Facilities

Announcement of Funding Availability

Intensive Case Management Services Using a High Fidelity Wraparound Model

Proposal Guidance and Instructions

AFA Title: *Intensive Case Management Services Using a High Fidelity Wraparound Model*

Targeting Region: Statewide

AFA Number: AFA 11-2016-CMH

West Virginia Department of Health and Human Resources
Bureau for Behavioral Health and Health Facilities
350 Capital Street, Room 350
Charleston, WV 25301-3702

For Technical Assistance please include the AFA # in the subject line and forward all inquiries in writing to:
DHHRBHHFAnnouncement@wv.gov

Key Dates:	
Date of Release:	February 1, 2016
TECHNICAL ASSISTANCE MEETING:	February 16, 2016 more details to follow
Application Deadline:	March 11, 2016 Close of Business–5:00PM
Funding Announcement(s) To Be Made:	March 21, 2016
Funding Amount Available:	Not to exceed $2,000,000

The following are requirements for the submission of proposals to the BBHHF:

- Responses must be submitted using the required Proposal Template available at http://www.dhhr.wv.gov/bhhf/afa/Pages/default.aspx

- Responses must be submitted electronically via email to DHHRBHHFAnnouncement@wv.gov with "Proposal for Funding" in the subject line. Paper copies of the proposal will not be accepted. Notification that the proposal was received will follow via email from the Announcement mailbox.

- A Statement of Assurance agreeing to these terms is required of all proposal submissions available at DHHR.WV.GOV/BHHF/AFA. This statement must be signed by the agency's CEO, CFO, and Project Officer and attached to the Proposal Template.

- To request additional Technical Assistance forward all inquiries via email to DHHRBHHFAnnouncement@wv.gov and include "Proposal Technical Assistance" in the subject line.

FUNDING AVAILABLITY

The Bureau for Behavioral Health and Health Facilities (BBHHF) is soliciting applications from licensed behavioral health agencies with direct children's service experience to act as local coordinating agencies for the development and delivery of a high fidelity wraparound model with supporting services, for youth who meet eligibility criteria, beginning in selected counties. The coordinating agencies and the Care Coordinators are expected to provide "conflict free" planning, coordination and facilitation of an Individualized Service Plan, to the extent possible. This funding recommendation was made possible by state general revenue funds with the availability of $70,000 for each care coordinator the applicant plans to hire. The $70,000 includes salary, fringe benefits, supervision, supplies, equipment, office, training, travel, and administrative costs for each care coordinator. Only those applicants who can demonstrate superior knowledge, proficiency and fiscal efficiency in the administration of a high fidelity wraparound approach will be eligible for the start-up funding.

In addition to grant funding, agencies will receive a daily rate of up to $136 for each child participating in this pilot project, depending on the level of care coordination needed. The daily rate does not include reimbursement for services for the child that are billable to Medicaid or otherwise supported through state grants (e.g., Family Engagement and Peer Support).

The service will be implemented in counties having the highest number of children and youth placed in acute psychiatric care and out of state psychiatric residential treatment facilities: **Berkeley, Cabell, Harrison, Kanawha, Marion and Raleigh counties.** Applicants are limited to agencies licensed as behavioral health providers. Agencies may apply to serve one or more counties and more than one agency may be selected to serve the same county or counties. Below is a table of the projected number of cases based on data regarding the target population in placement in the pilot counties. Please note that this number will increase as we move to serving the at risk population.

Kanawha – 36	**Berkeley – 23**	**Harrison - 17**
Raleigh - 16	**Cabell – 15**	**Marion - 15**

BBHHF anticipates that **Intensive Case Management Services Using a High Fidelity Wraparound Model** will be implemented in phases in the pilot counties beginning July 1, 2016. Successful applicants will hire and train staff over the course of a year. Approximately one half of the care coordinators will be hired, trained, and ready to accept referrals by July 1, 2016. The remaining half will be ready for referrals by November 1, 2016.

Section One: **INTRODUCTION**

The West Virginia Department of Health and Human Resources' Bureau for Behavioral Health and Health Facilities (BBHHF) envisions healthy communities where integrated resources are accessible for everyone to achieve wellness, personal goals and a self-directed future. The mission of the Bureau is to ensure that West Virginians with mental health and/or substance use disorders, intellectual/developmental disabilities, chronic health conditions or long term care needs experience quality services that are comprehensive, readily accessible and tailored to meet individual, family and community needs.

Within the Bureau, the Programs and Policy Section provides oversight and coordination of policy, planning, development, funding and monitoring of statewide community behavioral health services and supports. Emphasis is placed on function rather than disability, and improving planning and cooperation between facility and community-based services. Programs and Policy includes the Division on Alcoholism and Drug Abuse, Division of Adult Mental Health, Division of Child and Adolescent Mental Health, Division of Intellectual and Developmental Disabilities, and the Office of Consumer Affairs and Community Outreach.

Partnerships and collaboration among public and private systems, as well as with individuals, families, agencies and communities, are important components of the systems of care surrounding each person. The role of the Bureau is to provide leadership in the administration, integration and coordination of the public behavioral health system. The work is informed by results of a multi-year strategic planning process that includes critical partners in planning, funding and delivering services and supports.

The following Strategic Priorities guide services and service continuum development:

Behavioral Health System Goals	
Priority 1 *Assessment and Planning*	*Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the WV behavioral health service delivery system.*
Priority 2 *Capacity*	*Build the capacity and competency of WV's behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services.*
Priority 3 *Implementation*	*Increase access to effective behavioral health prevention, early identification, treatment and recovery management that is high quality and person-centered.*
Priority 4 Sustainability	*Manage resources effectively by promoting good stewardship and further development of the WV behavioral health service delivery system.*

Section Two: **PROGRAMMATIC DESCRIPTION**

Historically, parents searching for services for their children with serious emotional disturbances and other complex support needs have found access to only a limited array of services: traditional outpatient therapy, psychiatric residential treatment facilities, or inpatient psychiatric hospitals, all of which are funded through third party insurance, including Medicaid. Over twice as many youth are placed in a Psychiatrics Residential Treatment Facility (PRTF) by parents, as are youth who are in state's custody. In FY2014, 419 youth were placed in out of state PRTFs; 300 of were in parental custody. Parents begin to place youth out-of-state at an early age. In 2013-2014, 69 youth ages 10 or younger and 157 youth ages 11-14 were placed in a Psychiatric Residential Treatment Facility by parents. These youngsters make-up 75% of the youth placed out-of-state by parents. The counties with the most parental cases placed out-of-state are Kanawha, Raleigh, Berkeley, Harrison, Marion and Cabell Counties.

Additionally, West Virginia parents report difficulty and distress over the task of having to navigate multiple systems to obtain the needed services and supports for their children and themselves. Some parents describe feeling overwhelmed, outnumbered, and discounted, even as they acknowledge that everyone involved is trying to help. Meeting the daily demands of being the parent of a child with intensive and complex needs in and of itself requires extraordinary effort, dedication, and resourcefulness. Doing so with the help of West Virginia's public systems should not be more taxing for them than doing it alone.

The WV DHHR Bureau for Children and Families' Safe At Home initiative is using a Title IV-E Waiver demonstration to maximize the benefits of home and community-based services in conjunction with Medicaid paid behavioral and mental health services. Safe at Home will provide for intensive, individualized support services and an array of home and community-based services that will result in a potential reduction in congregate care for children in state custody. Title IV-E Waiver funds will support the establishment of an evidence-based wraparound model with supporting services.

For children in parental custody, the BBHHF is piloting initiatives to reduce unnecessary referral to acute psychiatric hospitals and Psychiatric Residential Treatment Facilities (PRTFs), and reduce the length of stay for those who are referred. BBHHF is partnering with the Bureau of Children and Families (BCF), the Bureau for Medical Services (BMS), the Bureau for Public Health (BPH), licensed behavioral health providers, and other organizations and entities with interest in and history in serving children with serious emotional disturbance, substance use or co-occurring disorders, as well as children/youth with co-existing disorders. Funding can expedite and expand the development and implementation of services that have been researched and demonstrated as effective in reducing reliance on residential treatment for youth, but must also produce data regarding outcomes to support the BBHHF's capacity to make data informed decisions regarding program effectiveness, continuation, expansion and sustainability.

As services in the state are developed, the needs of all youth, regardless of custody, need to be met. If parents do not have access to community services, such as intensive "wrap-around" planning and support, peer support and system navigation, crisis services, intensive home and school-based services, etc., then parents will continue to be forced to seek treatment outside WV to meet their needs.

High Fidelity Wraparound: A System of Care Approach

The System of Care model is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving services, increasing access to services, and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with serious emotional disturbances and their families. West Virginia adopted the System of Care values over 20 years ago, and since that time, much work has been done to instill these values in case work practice. Children's behavioral health and child welfare policies and practice curricula have been revised to reflect these values.

Success of a High Fidelity Wraparound process to reduce reliance on psychiatric congregate care will depend on the support and participation of many stakeholders in West Virginia: families, youth, judges, court personnel, child welfare workers, mental health agencies, schools, community based service agencies, residential care providers, and funders. Understanding the populations served and how to best meet their needs is the key to developing an effective and responsive Wraparound process. Intensive Case Management Services Using a High Fidelity Wraparound Model will provide for trauma-focused treatments delivered in an environment that safely preserves family relationships and empowers families to help meet their own needs.

The purpose of creating Intensive Care Coordination using a High Fidelity Wraparound Process in West Virginia is to:

1. Provide service coordination through a definable planning process, resulting in a unique set of community services and natural supports that is individualized for a child and his/her family which will allow them to achieve a positive set of short, intermediate and long-term outcomes;
2. Reduce the number of out of state placements for psychiatric care (in an acute care facility or PRTF);
3. Reduce recidivism and increase positive community-level outcomes for children and youth returning from out of state psychiatric placements to their home communities;
4. Produce data regarding outcomes to support the WV DHHR's capacity make data informed decisions regarding program effectiveness, continuation, expansion and sustainability.

Section Three: **SERVICE DESCRIPTION**

Intensive Case Management Services using a High Fidelity Wraparound Model

Target Population(s):

- Children ages 0 – 21
- With a mental health and or substance abuse diagnosis that resulted in functional impairment which substantially interferes with or limits* the child's role or functioning in family, school, or community activities, as demonstrated by:
    - The child has current or past history of symptoms or behaviors indicating the need for a crisis intervention due to suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk-taking behavior (running away, sexual aggression, sexually reactive, or substance use). or
    - The child's symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of the child's mental health or substance abuse condition, requiring intensive, coordinated clinical interventions.
- Who require services from two or more child serving systems
- Who are at risk of placement, or currently placed in a psychiatric treatment facility or acute care psychiatric hospital who cannot return home without extra support, linkage, and services provided by wraparound, and
- Who are in the legal custody of their parent/caregiver.

Description of Services

The Wraparound process promotes successful outcomes through coordination, creation, and individualization of services and supports to fit the unique needs of the child and family while building upon their strengths. Core components will be delivered through phases, as outlined in the National Wraparound Initiative *"The Wraparound Process User's Guide-A Handbook for Families": Engagement, Planning, Implementation and Transition*" found at. http://nwi.pdx.edu/pdf/Wraparound_Family_Guide09-2010.pdf. Intensive Case Management Services using a High Fidelity Wraparound Model Wraparound Program will be based on ten (10) key wraparound principles:

1. Family voice and choice: Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

2. Team Based: The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.

3. Natural Supports: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

4. Collaboration: Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

5. Community Based: The Wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and most integrated least restrictive settings possible, and that safely promote child and family integration into home and community life.

6. Culturally Competent: The Wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

7. Individualized: To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

8. Strengths based: The Wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and the assets of the child and family, their community, and other team members.

9. Persistence: Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.

10. Outcome based: The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

The primary goals of the Wraparound process are to support family strengths, promote community investment and ownership, and provide the needed resources to families to improve child and family well-being and reduce the risk of behavioral health crises and out of home placement. The work of wraparound is completed using seven core components:

1. Care Coordination;
2. A maximum caseload of no more than 10 families per care coordinator (unless otherwise indicated by objective assessment and family determination);
3. Family decision making;
4. Tailored service plans and outcomes for each family;
5. Assessments for every family member;
6. Face-to-face meetings with the family at location(s) of their choice, and family team meetings at least monthly;
5. Shifting families from reliance on professional to natural supports.

The benefits of a wraparound process include:

1. One child and family team across all service environments;
2. Creates a unified and seamless transition as youth and families move through the system;
3. Helps families build long-term connections and supports in their communities;
4. Provides concurrent community work while youth is in residential care for a smooth transition home;
5. Reduces the occurrence and negative impact of traumatic events in a child's life;
6. Provides access to mobile crisis support, 24 hours per day, seven days per week;
7. Provides crisis stabilization without the need for youth to enter/re-enter residential care;
8. Reduces the length of stay in congregate care.

Intensive Case Management Services using a High Fidelity Wraparound Model includes the following phases:

1) **Engagement and Planning Phase** (not to exceed 90 days). The child is in the home when services begin. The child and family are often in crisis and formal services are not yet in place. The wraparound team engages the family, completes needed assessments, develops treatment plans, and initiates services to ensure the family is safe.

   Please note that this phase could also include a Pre-Community Integration phase (not to exceed 90 days). The child is in residential care at the time services begin. This phase is limited to youth currently in residential care who need intensive wraparound services in order to return home.

2) **Implementation Phase** (not to exceed 6 months). Over time the child and family should begin to need less intense care due to the coordinated services and supports that are in place. The family and child should begin to develop skills to navigate systems and to manage issues through initiation of natural supports.

3) **Maintenance Phase** (not to exceed 6-9 months). The frequency and intensity of formal services further decreases as the family begins to rely on the community and natural supports. The family is working toward discharge from Intensive Care Coordination.

4) **Transition Phase** (not to exceed 9 months to 1 year). Formal intensive care coordination services that were part of the family's treatment plan ends. The discharge plan is concrete, service-based, with plans for the future utilization of natural supports and community involvement. A mentor may be assigned to the child or children to assist with the transition. A mentor is an adult who can spend one-on-one time with a child and be a positive role model to help promote positive self-esteem and improve social, communication, and problem solving skills during the transition period. It is anticipated that most families will be transitioned to informal supports within 12 months.

Note that not all families accepted for the **Intensive Case Management Services using a High Fidelity Wraparound Model** service will need the most intensive level of care coordination (one care coordinator for every ten families). Some children and families, after initial assessment and transition planning, will require and agree to a less intensive level of care coordination/support (one care

coordinator for every twenty families). A standardized assessment process will be used to match families to levels of care. (See Child and Adolescent Needs and Strengths Assessment (CANS) below

Intensive Case Management Services using a High Fidelity Wraparound Model will require enhancement of existing services and development of core services which will include but not be limited to:

- Assessment and evaluation;
- Individualized wraparound service planning;
- Intensive case management;
- Outpatient therapy: individual, family and group;
- Medication management;
- Day treatment;
- Positive behavior support and skills training;
- Intensive home-based mental health services;
- School-based behavioral health services;
- Substance abuse intensive outpatient services;
- Crisis services;
- Mobile crisis response;
- Youth coaching;
- Peer support;
- Respite services;
- Therapeutic Mentoring;
- Therapeutic foster care.

The success of **Intensive Case Management Services using a High Fidelity Wraparound Model** is dependent on community collaboration with linkages to:

- Department of Education, Regional Education Service Agency (RESAs) and local schools;
- Office of Maternal Child and Family Health programs;
- Child welfare community organizations and other children services' provider agencies;
- Local mental and behavioral health providers;
- Medical providers;
- Local Department of Health and Human Resources;
- Family Resource Networks, Regional Summits, and Community Collaboratives;
- Programs/services for children/adults with disabilities;
- Employment programs;
- Circuit and Family Courts;
- In Home Family Education Programs;
- Children's Behavioral Health Providers;
- Adolescent and adult substance abuse programs;
- Community civic organizations;
- Local faith-based communities.

Entry Point – referral from Regional Clinical Coordinator

Parents that have a child placed in an out of state Psychiatric Residential Treatment Facility (PRTF) or an in-state acute care hospital for psychiatric care, and who retain custody, will be referred by the Bureau for Medical Services, or may self-refer, to a Regional Clinical Coordinator to apply for this service.

The Regional Clinical Coordinator will work the family to assure administration of the Child and Adolescent Needs and Strengths (CANS). The CANS is an assessment process and multi-purpose tool developed for children's services to: 1) support decision making, e.g., level of care and service planning; 2) facilitate quality improvement initiatives, and 3) monitor the outcomes of services. The measure is based on research findings that "optimally effective treatment of children and youth should include both efforts to reduce symptomatology and efforts to use and build strengths." (Lyons, 2009)

(http://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/)
Lyons, JS & Weiner, DA (EDS) (2008). Strategies in behavioral healthcare : Total Clinical Outcomes Management. Civic Research Institute, New York
Lyons, JS (2009) Communimetrics: A measurement theory for human service enterprises. New York, Springer.

The Regional Clinical Coordinator will refer the family to a local provider of **Intensive Case Management Services using a High Fidelity Wraparound Model**. If requested by the family to gain additional clinical input and resources, the Regional Clinical Coordinator will participate in quarterly meetings with the family and Care Coordinator, to offer independent perspective and to facilitate access to review by the Regional Clinical Review Team.

Section Four: **PROPOSAL INSTRUCTIONS/REQUIREMENTS**

All proposals for funding will be reviewed by the BBHHF staff for administrative compliance, service need, and feasibility. Proposals must contain the following components:

- A completed Proposal for Funding Application, available at http://www.dhhr.wv.gov/bhhf/afa/Pages/default.aspx.

- A Proposal Narrative consisting of the following sections: Statement of Need and Population of Focus, Proposed Evidence-based Service/Practice, Proposed Implementation Approach, Staff and Organization Experience, Data Collection and Performance Measurement.

- Together these sections may not exceed **fifteen (15)** total pages. Applicants must use 12 point Arial or Times New Roman font, single line spacing, and one (1) inch margins. Page numbers must also be included in the footer.

- The following is an outline of the Proposal Narrative content:

  - ✓ Statement of Need and Population of Focus: Describes the need for the proposed service(s). Applicants should identify and provide relevant data on the target population to be served, as well as the geographic area to be served, to include specific Region/county(es) and existing service gaps. Applicants should also explain how the community currently addresses the need for behavioral health/psychiatric care for children and youth in their parents' custody;

  - ✓ Proposed Evidence-Based Service/Practice: Clearly delineates the program/services being proposed and goals and objectives for the proposed service(s) and list all evidenced-based practices (EBPs) that will be used. Applicants should also describe how services/interventions will be trauma informed, culturally appropriate, promote family engagement, and support the key principles of the West Virginia System of Care. Applicants should also identify creative outreach methods to serve geographically isolated families.

  - ✓ Proposed Implementation Approach: Describes how the Applicant intends to implement the proposed service(s) to include:

    - A description of the strategies/service activities proposed to achieve the goals and objectives identified above, those responsible for action, and a one (1) year/ twelve (12) month timeline for these activities. Include planning/development, training/consultation, implementation, and data management.
    - A description of program sustainability, including how alternative funding sources will be exhausted. Grantee must seek reimbursement from any and all third party administrators or coverage providers including but not limited to: private insurance; Medicaid and the Children's Health Insurance Program (CHIP).
    - An explanation of how the agency will structure and develop wraparound programs to meet the specific needs of the target populations. It should identify the specific service development needs and barriers in each community and how the applicants will work collaboratively to build the necessary wraparound structures, supports and services.
    - Information on services and community supports that are currently available in the

county/counties the applicant desires to serve. If service development is required in order to be able to provide a community-based alternative to residential behavioral health services, applicants must explain what additional services are needed, how current services may need to be enhanced and how the applicant will collaborate with existing stakeholders to develop what is needed, including identifying and add versify barriers.

- The unduplicated number of individuals to be served annually.

✓ Staff and Organization Experience: This section should describe the Applicant's existing capacity to carry out the proposed service(s), to include its experience and qualifications to reach and serve the target population.

✓ Data Collection and Performance Measurement: This section should describe the information/data the Applicant plans to collect, as well as their process for: using data to manage and improve quality of the service, ensure each goal is met and assess outcomes within the target population.

- References/Works Cited: All sources referenced or used to develop this proposal must be included on this page. This list does **not** count towards the **fifteen (15) page** limit.

The attachments **do not** count toward the **fifteen (15) page** limit.

- Attachment 1: Targeted Funding Budget(s) and Budget Narrative(s).

  ✓ Targeted Funding Budget (TFB) form, includes sources of other funds where indicated on the TFB form. A separate TFB form is required for any capital or start-up expenses. This form and instructions are located at http://www.dhhr.wv.gov/bhhf/forms/Pages/FinancialForms.aspx

  ✓ Budget Narrative for each Targeted Funding Budget (TFB) form, with specific details on how funds are to be expended. The narrative should clearly specify the intent of and justify each line item in the TFB. The narrative should also describe any potential for other funds or in-kind support. The Budget Narrative is a document created by the Applicant and not a BBHHF Fiscal form.

- Attachment 2: Applicant Organization's Valid WV Business License

- Attachment 3: Memorandums of Understanding (MOUs) and letters of support must be submitted with the application to document established partnerships between community behavioral health and other potential community organizations. Please list full partner information, including agency name, address, phone, key contact person and email address.

The attachments **do not** count toward the **fifteen (15) page** limit.

Section Five: **EXPECTED OUTCOMES / PERFORMANCE MEASURES**

Expected Outcomes:

1. Youth are able to safely remain or return home to other safe living arrangement and in their school or work setting;
2. Parents and youth have increased skills and strengths and their needs are reduced;
3. Parents communicate and demonstrate, through actions, a higher level of skill to deal with youth behaviors and needs;
4. Parents communicate improved well-being and satisfaction in their role as a parent.

Performance Measures:

1. Maintain and provide documentation of ALL activities related to service area(s) indicated by:
   a. Number of Unduplicated Persons Served by Type of Activity
   b. Number of Unduplicated Persons Served by Age, Gender, Race and Ethnicity, and Diagnosis(-es)

2. Maintain and provide documentation related to the following:
   a. Number of Cross Planning (partnering/multi-system collaborative) initiatives, all service activities implemented with other sectors, indicating type and number
   b. Number and type of professional development trainings attended and provided
   c. Number, type (focus groups, surveys, or key-informant interviews), and aggregate results of consumer feedback activities conducted

3. Maintain and provide additional data as related to the Expected Outcomes/Performance Measures within 25 calendar days of the end of each month in accordance with applicable BBHHF Data Reporting. The performance measures used to measure the success of the program will be included in the Statement of Work and will be provided in a format posted for grantees on the BBHHF website. Measures may include:

   - Number of youth who are referred for ICC/Wraparound
   - Number of youth who are accepted into ICC/Wraparound
   - Number of youth who were closed for services with names
   - Number of youth who are able to remain or return home and in their school without experiencing expulsion or out-of-school suspension
   - Number of youth who returned from out of state residential placement back to WV
   - Number of parents and youth who have increased skills and strengths and their needs are reduced, as evidenced by CANS scores
   - Number of parents with a higher level of skill to deal with youth behaviors and needs and enhanced well-being and satisfaction in their role as a parent, as evidenced by improved CANS scores.
   - Caseload ratio of wraparound facilitators
   - Percentage of turnover of wraparound facilitators

- Number of youth that had more than 1 wraparound facilitator
- Percentage of families with initial contact within 72 hours
- Percentage of families with a face-to-face family joining meeting within 5 days
- Percentage off CANs completed within 14 days of case referral
- Number of children who maintained grade level
- Number of children who did not require out of home crisis intervention
- Number of children who were maintained in the home
- Number of families who established new or existing community / natural supports this month (list types of natural and / or community supports

In addition the successful applicants will be required to submit financial reports which include revenue received by the agency for wraparound services including amount, purpose, and source and all expenditures by the agency by service and amount.

Section Six: **CONSIDERATIONS**

LEGAL REQUIREMENTS

Eligible applicants are public or private organizations with a valid West Virginia Business License and/or units of local government. If the applicant is not already registered as a vendor in the State of West Virginia, registration must either be completed prior to award or the vendor must demonstrate proof of such application.

The Grantee is solely responsible for all work performed under the agreement and shall assume all responsibility for services offered and products to be delivered under the terms of the award. The State shall consider the designated Grantee applicant to be the sole point of contact with regard to all contractual matters. The grantee may, with the prior written consent of the State, enter into written sub agreements for performance of work; however, the grantee shall be responsible for payment of all sub awards.

START UP COSTS

Applicants who wish to request reasonable startup funds for their programs must submit a separate "startup" target funded budget (TFB) and budget narrative along with their proposals. For the purposes of this funding, startup costs are defined as non-recurring costs associated with the initiation of a program. These include costs such as fees, registrations, training, equipment purchases, renovations and/or capital expenditures.

For the purposes of proposal review, all startup cost requests submitted by the applicant will be considered to be necessary for the development of the proposed program. If, when taken together, the startup costs and program costs exceed funding availability BBHHF will contact the applicant organization and arrange a meeting to discuss remedial action.

FUNDING REIMBURSEMENT

All grant funds are awarded and invoiced on a reimbursement basis. Grant invoices are to be prepared monthly and submitted with and supported by the Financial Report and Progress Report to receive grant funds. The grant total invoice should agree with amounts listed on the Financial Report and reflect actual expenses incurred during the preceding service period. All expenditures must be incurred within the approved grant project period in order to be reimbursed. Providers must maintain timesheets for grant funded personnel and activities performed should be consistent with stated program objectives.

REGIONS IN WEST VIRGINIA

The WV Bureau for Behavioral Health and Facilities utilizes a six (6) Region approach:

Region 1: Brooke, Hancock, Marshall, Ohio, and Wetzel Counties

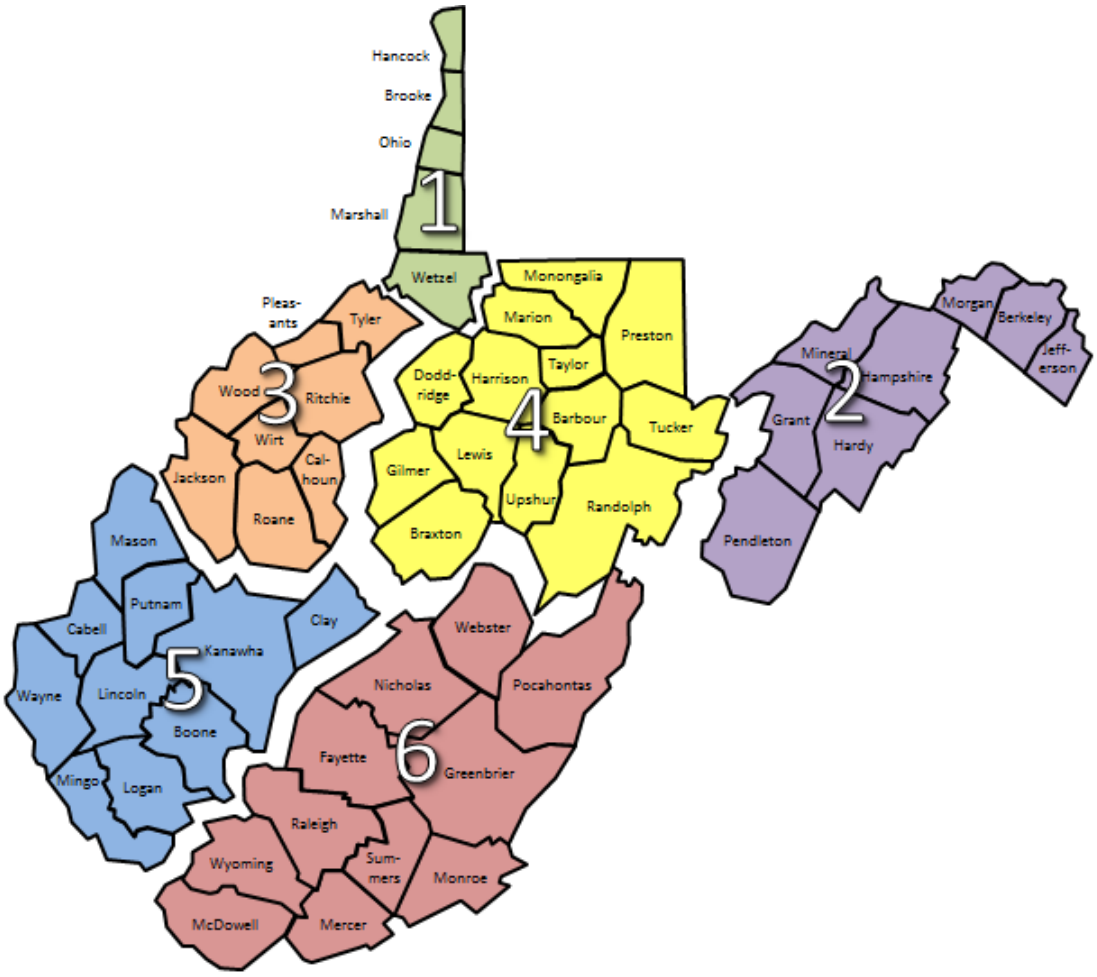
Region 2: Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, Morgan, and Pendleton Counties

Region 3: Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, and Wood Counties

Region 4: Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, and Upshur Counties

Region 5: Boone, Cabell, Clay, Kanawha, Lincoln, Logan, Mason, Mingo, Putnam, and Wayne Counties

Region 6: Fayette, Greenbrier, McDowell, Mercer, Monroe, Nicholas, Pocahontas, Raleigh, Summers, Webster, and Wyoming Counties



Other Financial Information

Allowable Costs:

Please note that Departmental Policies are predicated on requirements and authoritative guidance related to Federal grants management and administrative rules and regulations, Grantees shall be required to adhere to those same requirements when administering other DHHR grants or assistance programs, the source of which is non-Federal funds (e.g. state-appropriated general revenue and appropriated or non-appropriated special revenue funds) unless specifically provided direction to the contrary.

Cost Principles:

Subpart E of 2 CFR 200 establishes principles for determining the allowable costs incurred by non-Federal entities under Federal awards. The Grantee agrees to comply with the cost principles set forth within 2 CFR 200 Subpart E, regardless of whether the Department is funding this grant award with Federal pass-through dollars, state-appropriated dollars or a combination of both.

Grantee Uniform Administrative Regulations, (Cost Principles, and Audit Requirements for Federal Awards):

Title 2, Part 200 of the Code of Federal Regulations (2 CFR 200) establishes uniform administrative requirements, cost principles and audit requirements for Federal awards to non-Federal entities. Subparts B through D of 2 CFR 200 set forth the uniform administrative requirements for grant agreements and for managing Federal grant programs. The Grantee agrees to comply with the uniform administrative requirements set forth within 2 CFR 200 Subparts B through D, regardless of whether the Department is funding this grant award with Federal pass-through dollars, state appropriated dollars or a combination of both.